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CLINICAL MEDICINE

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CLINICAL MEDICINE
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EPTEMBER
1946

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Richards, R. K., and Perlstein, M. A. (1945), Tridione, A New Experimental Drug for the Treatment Convulsive and Related Disorders, Proc. Chicago Neurological Soc., Jan. 9; and (1946), Arch. Neurol. and Psychiatry, 55:164, February.

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Hypotension (Hypopiesia)

By S. WATSON SMITH, M.D.
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The distinctive sign of hypotension in the adult is a systolic maximal blood pressure equal to 110 mm. of mercury (Hg.) or less with a diastolic minimal presure ranging below 70 mm. Hg. which is confirmatory, but often remains undetermined because of the transitional sound being indistinct or inaudible. These figures, though approximate and arbitrarily fixed, constitute the upper signposts of hypopiesia. Though for the adult subnormal, a systolic pressure lower than 110 mm. is not incompatible with an active, even energetic life, and may not reveal itself unless or until becoming a feature of associated disease.

To classify: Cases fall easily into one or the other of two clearly definable groups:

- Hypotension
  - Primary or Essential (Hypopiesia)
    - Sthenic — of natural occurrence; the so-called permanent type; symptomless; comprising the active and athletic.
    - Asthenic — temporary, symptom-producing, with a disposition to hypotensive attacks; the ambulatory, common, consulting-room case.
  - Secondary (Hypopiesis)
    - Symptomatic — of co-existing disease.

In the consciously ill from too low or falling pressure are a number of accompanying symptoms for the most part subjective which, taken together, point to hypopiesia, of a degree to be measured by sphygmomanometer. It is the rule that the patient is ambulant, going about his business as usual, but in anxious doubt about his health because of spells of dizziness and weakness. The stipulation must be made that an established diagnosis of hypopiesia should be based only upon a series of instrumental recordings, taken by the stethoscopic method, say, weekly; not on a single, solitary measurement.

The Clinical Features

A disposition to fleeting hypotensive attacks excited by emotion, more often by digestive disturbance, may as a leading sign bring the disorder to light. Here are the main symptoms, enumerated: (1) Dizziness on change of posture to the upright—'postural hypotension'—occurring suddenly, giving rise to apprehensive fear with loss of self-confidence that drives the patient to seek medical advice. (2) Asthenic attacks when, perhaps for the space of hours of a day, feelings of weakness overcome the patient to deprive him of the power of physical, though seemingly not of intellectual, effort. (3) Inability to remain standing beyond minutes without this inducing faintness, pallor, sweating, nausea, even up to vaso-vagal fainting with loss of consciousness; hypopietics are bad "standers." (4) High-coloured, cyanotic skin with sluggish terminal circulation in nose, cheeks, ears, fingers and toes; intolerance of cold; (5) Awareness while at rest of throbbing pulsation in head, hands and feet synchronous with the pulse beat. (6) The state is not un-

common in young and middle-aged men of spare build and steady, competent, unaggressive habit; unusual in women and in the obese; not found in the labouring man. (7) Near faints with mental halts or black-outs that are momentary, with the complaint of seeming to 'go all to pieces' and of feeling powerless even to think when these threaten. (8) Hypopietics need long sleep: as if their reserve of strength being too narrow, lengthy hours of rest are called for to recover energy enough for the next day's work.

The Pathogenesis

However the cause is considered, the inference drawn is that asthenic hypopiesia is brought about by lack or loss of vaso-motor tone and control, with resulting capillary stasis. For this reason, blood would appear to pool in the roomy splanchnic circulation, to slow the blood flow and conduce to faulty aeration; perhaps to deplete the more distant parts of the body. It has been suggested that the muscularly weak, slack abdominal wall favours this happening; but an oppressive hypotension is not seen in women, whether parous or otherwise, being most often detected in men. One reason for this may be the habit in women of wearing the corset. In further explanation of the mode of production, going a step farther back: a functional neuromuscular atony of some cause and kind must underlie the vaso-motor imbalance, itself of constitutional or autotoxic origin, or both. Heredity is believed to dispose to the condition in a few.

Management

An abdominal belt is a first necessity, applied low down over the hips to give firm support and an uplift to the abdomen. The best for constant use is the ostler's broad, buckled, web belt which is strong and lasting. The so-called surgical belt, as usually designed, is useless for the purpose. The belt is worn when up and about, not while in bed. If feelings of faintness or dizziness occur, the patient should tighten the belt and lie down till recovered. In his relief in the solid benefit felt by wearing the belt, he will cling to it tenaciously.

As to drugs: temporary though evanescent rises in pressure are effected by benzedrine sulphate, though caution in its use is very necessary; so also with adrenalin or ephedrine. Particularly in the elderly, attempts to raise the pressure by the giving of drugs that exert a forcible presser effect may prove dangerous; in any case, the method seems to be uncalled for and is unsafe, keeping in mind those drugs presently available. Neither is the raising of pressure by any medicament, though succeeding for the moment, likely to be continuous or controllable enough at any time for the end to justify the means; nor is this the whole cure, but only the smaller part of it. As interval remedies, for extended use, best are iron in massive dosage, medicinal glucose in quantity, and strychnine, any and all of which are indirectly valuable.

The dietary needs no modifying, indeed, a full mixed ordinary diet is indicated, with an adequate hydration, the minimal adult daily allowance of all fluids being four imperial pints.

When hypopiesis is symptomatic, as in coronary occlusion, adrenal insufficiency, or other malady, treatment is that of the concomitant disease.

Conclusion

A hypopiesia registered by manometer can be taken to be real and abnormal if additional symptoms show up in mutual support to confirm the diagnosis. Significant amongst these are: asthenia, dizziness while upright, and inability to stand about. Essential hypopiesia is to be distinguished from a hypopiesis symptomatic of other present disease: the two will be differentiated by collating all symptoms and signs, and by charting repeated pressure readings taken by sphygmomanometer.

The chief incidence of hypotension shows itself in youth and middle-age: by its persistence into later life inducing a limitation of effort and compelling a constant slowing of the pace in the elderly few afflicted, in whom as age had advanced, the natural rise in pressures due to arterial degenerative changes did not take place. Even so there is ample evidence that abnormally low pressures do not reduce the expec-

tation of life; on the contrary, are known to increase it. Not seldom, hypopiesia is found to sow the seeds of neurasthenia; harnessed together, each is liable to perpetuate the other.

Most often seen in men, essential hypotension is rarely if ever found in women, who normally possess a higher average level of blood pressure especially after the menopause. Reassurance and enough rest are needed, not omitting massage and regular physical exercises practised at first in the recumbent. Whether for immediate or protracted use, no drug is altogether suitable. Whatever the cause, the remedy is the same: A supporting low-placed broad abdominal web belt firmly adjusted. This last is usually declared by the sufferer to be a helpful, invigorating part of the treatment; the patient's word for it need not be gainsaid, but should be accepted.

Like its opposite number in hypertension, hypopiesia is to be accounted a disorder, often latent, rather than a disease, to be righted by first removing the cause if at all possible. And it is a known fact that, although seizures are transient and troublesome, hypopiesia of itself is neither morbid nor mortal.

Discussion

Hypopiesis is not a disease but is a manifestation associated with a variety of clinical problems. An abnormally low blood pressure associated with shock, myocardial failure, endocrine problems, or following infections needs no special emphasis.

Those physicians doing clinical work are also aware that a blood pressure below the accepted upper limit of 110 mm. Hg systolic is compatible with an active healthy existence at all ages, but usually noted below forty years of age.

It is in the constitutionally inadequate that so much confusion exists. These patients invariably manifest a hypotension in addition to their other symptoms of exhaustion, inability to concentrate, headaches, dizziness, palpitation, syncope, numbness of arms and legs, belching, and a spastic bowel. Often a physician is tempted to attribute these symptoms to the hypotension instead of taking time to explain to the patient the need to live within his limits, not to assume too much responsibility, or to try to keep up with his nearest competitor. His work must be adjusted to his functional capacity, and he must conduct himself moderately in all things.

The happiness of the patient is essential and the sooner he learns how much he can and can not do, the more quickly he can be made comfortable. Reassurance, rest, and an understanding of his limitations is more important than to have him place false reliance on a bottle of medicine or some gadget.—G. E. MOUNTAIN, M.D.

Biliary Calculi

The physician who does not recommend surgery for biliary calculi regardless of the type is definitely responsible for a portion of the surgical mortality.

The surgeon must attempt to improve the patient's condition *before* surgery and be careful of the technic which he uses.

He must: (1) Use the cholecystostomy more frequently; (2) Explore more common ducts and be more thorough in his exploration; (3) Explore the duct before doing the comtemplated cholecystectomy so the gallbladder can be used for an anastomotic procedure if necessary; (4) Avoid injuries to the ducts, vessels and hollow visera; (5) Remove all stones in doing a cholecystostomy; (6) Perform more liver function tests to attempt to ascertain, if possible, the state of the liver; and (7) Administer the best in postoperative care, remembering that the early use of blood or plasma is of far greater value than its administration to a moribund patient.—C. A. BACHHUBER, M. D., in *Am. J. Surg.*, March, 1946.

Colles' Fracture

By H. HERMAN YOUNG, M.D.,*
Rochester, Minn.

IN DUBLIN, in 1814, Abraham Colles first described a typical fracture of the lower end of the radius which today bears his name.

The original injury described by Colles was a fracture occurring in the distal end of the radius which resulted in dorsal displacement of the distal fragment. He estimated that this fracture was 4 cm. (1½ inches) above the articular surface of the radius at the wrist. Since this observation was made before the advent of roentgenographic examinations and without the use of a dissected specimen, it is not strange that Colles placed the line of fracture too high. Actually the injury occurs within the distal inch of the radius and common medical parlance now classifies as Colles' fractures all fractures occurring in the cancellous portion of the distal 2.5 cm. (1 inch) of the radius, whether the distal fragment is merely impacted and remains in good position or is loose and displaced dorsally.

The same type of fracture in this region with ventral displacement of the distal fragment (Smith's fracture) has come to be known as "reverse Colles' fracture," "chauffeur's fracture" or "backfire fracture" because of its relation to the Colles' fracture or to frequent association of the injury produced by accidents while cranking gasoline engines. This disagreement in terminology is minor, however, compared to the major importance of the injury and the frequency with which the fracture is observed.

Colles' fracture is one of the most frequently observed fractures, and unless properly treated serious impairment of function of the hand and wrist may result. Disabilities and deformities of the hand and wrist are of sentimental and of enormous economic importance, hence, any physician or surgeon who treats fractures at all should be prepared to treat adequately a Colles' fracture.

*Section on Orthopedic Surgery, Mayo Clinic.

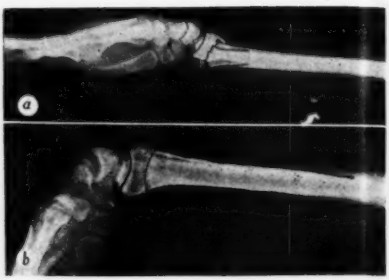

Fig. 1. Lateral view of Colles' fracture: *a*, before reduction showing dorsal displacement of distal radial fragment and silver-fork deformity; *b*, same fracture reduced showing re-establishment of normal downward angulation of the articular surface of the radius.

The Anatomy

The articulation of the forearm with the carpus involves principally the radius. The ulna is not in direct contact with the proximal row of carpal bones but is separated from them by the so-called triangular fibrocartilage. Thus *the radius alone receives the shocks transmitted by falls on the hand.* The radio-carpal joint is prolonged upward between the radius and ulna as the distal radio-ulnar articulation and thus all motions of the wrist are exclusively performed in the radio-carpal joint. Failure to re-establish the joint surfaces after injury leads to impaired function.

Landmarks

As an aid to proper treatment of injuries about the wrist the physician should be familiar with a few anatomic landmarks. The styloid process of the radius is readily palpable on the lateral surface of the wrist and that of the ulna on the medial surface. It should be noted that the tip of the radial styloid lies normally about 1.25 cm. distal to the tip of the ulnar styloid; this relationship is important in detecting injuries to the wrist as well as one of the criteria for accurate reduction of a Colles' fracture.

The head of the ulna forms a prominence posteriorly and the dorsal radial

tubercle makes a palpable landmark on the back of the wrist in line with the cleft between the index and middle fingers. On the volar surface of the wrist the lip of the distal end of the radius can be palpated. Above this lip lies the slightly concave volar surface of the lower portion of the radius.

Mechanism of Injury

Colles' fractures occur mainly among elderly adult persons but can occur at any age and may be observed in greenstick fractures or epiphyseal separations in children. The mechanism of the injury has been variously described. The fracture usually occurs in a fall on the outstretched and extended hand or it may be produced by a direct blow to the wrist, such as occurs when the crank of a gasoline engine strikes the wrist sharply during a backfire.

In the typical Colles' fracture the carpal bones are driven forcibly against the lower end of the radius while the wrist is hyperextended. In reverse Colles' fractures the same force is exerted but the wrist is flexed. The line of fracture is roughly transverse and some degree of impaction of the fragments usually results because of failure of the distal fragment completely to clear the proximal fragment in its displacement. Comminution of the distal fragment is observed frequently and often a linear fracture extending into the joint will complicate the situation.

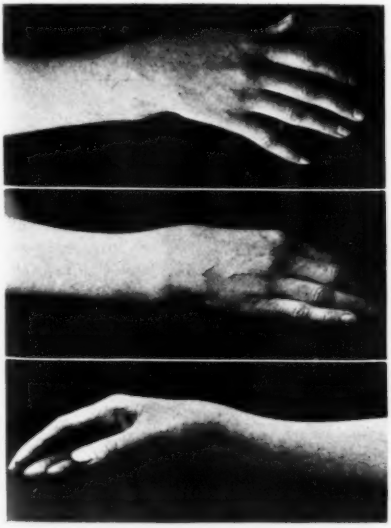

Fig. 2. Deformities of the wrist produced by Colles' fracture.

Fig. 3. Anteroposterior and lateral views of reverse Colles' fracture.

The distal fragment of bone in a typical Colles' fracture is displaced upward and backward and is usually deviated to the radial side. This causes the articular surface of the radius to point forward and upward (toward the dorsal surface (Fig. 1a)) instead of forward and downward as in the normal wrist (Fig. 1b). This typical displacement produces the classic silver-fork deformity of the wrist (Fig. 2). When the distal radial fragment is displaced mesially and backward, as in a reverse Colles' fracture, the so-called gardener's spade deformity of the wrist is produced (Fig. 3).

Clinical Aspects

Any adult sustaining an injury to the wrist should be suspected of having suffered a Colles' fracture. Pain, tenderness, swelling and disability are usually present but if the fragments are not displaced, the typical deformity is not present and it may be necessary to make a roentgenogram before the diagnosis can be made. In typical cases with dorsal displacement of the distal fragment the silver-fork deformity is obvious. The patient generally supports the hand and

wrist with the opposite hand and holds the wrist extended in a straight line with the forearm. All wrist and finger motions are painful. It will be noted that the wrist is abducted (deviated to radial side) and there is an undue prominence of the distal end of the ulna. The radial styloid process will be found on a line with or even slightly proximal to the tip of the ulnar styloid process rather than 1.5 cm. distal to it as in the normal wrist. There may be tenderness over the ulnar styloid process if this process is fractured but a fracture there is not necessarily a part of all Colles' fractures. Although fractures with displacement are easily recognized, roentgenographic examination is essential not only in evaluating the treatment to be instituted but for medicolegal reasons as well.

Treatment

Reduction, retention and restoration of function are the three "R's" in the treatment of Colles' fracture. Reduction should be carried out as early as possible after the injury and can be accomplished more easily if it is done before the period of severe swelling.

Local Anesthesia

Either general or local anesthesia may be used. If the latter type of anesthesia is chosen, a small wheal is made on the dorsum of the wrist just proximal to the site of the fracture by injecting a 2 per cent solution of procaine hydrochloride. A few cubic centimeters of this solution are then injected into the soft tissues down to the dorsal surface of the radius. The needle is passed along the surface of the bone until it enters the hematoma at the site of fracture. When this occurs, a little blood may be aspirated. When the needle is in this place, 10 c.c. of the same solution is injected into the site of the fracture of the radius and the needle is withdrawn. A similar procedure will anesthetize the site of the fracture at the ulnar styloid process if this process is fractured also, but only a few cubic centimeters of procaine will be found necessary there. After from five to ten minutes have elapsed after the injection, anesthesia usually is complete and manipulation can be carried out. This method surpasses a complete wrist block in that local anesthesia is produced without the accompanying distortion caused by the complete block.

Fig. 4. Two common steps in manipulation for reduction of Colles' fractures.

(Note: Figures 1 to 4 have been reproduced, by permission, from Ghormley, R. K., Macey, H. B. and Young, H. H.: Fractures. In Lewis, Dean: *Practice of Surgery*. Published by the W. F. Prior Company.—Ed.]

Fractures Without Displacement

In Colles' and reverse Colles' fractures without displacement, immobilization of the wrist in ulnar deviation and 180 degrees extension is all that is necessary. Splints or plaster molds extending from the elbow to the metacarpophalangeal joints will suffice. At the end of two weeks the splints are removed daily for a period of active motion and can be discarded entirely in six weeks.

Fractures With Displacement

In Colles' fractures with displacement reduction is necessary. The method most widely used is that in which the fragments are levered into position (fig. 4 top). The patient's elbow is first flexed to form a right angle and the forearm is placed in the midposition with regard to rotation. The physician then grasps the upper fragments with one hand and holds the lower fragments with the opposite hand. Steady traction is then applied and the deformity is exaggerated by hyperextension in order to release the impacted fragments and restore the length of the radius. The wrist is then flexed and deviated to the ulnar side

while pressure is placed against the distal fragment of the radius by the thumb on the dorsum of the wrist. If the maneuver is successful, the wrist will remain flexed, the silver-fork deformity will be gone and the normal relationship of the radial and ulnar styloid processes will be re-established. The roentgenogram should reveal that the articular surface of the radius is pointing forward and downward as in the normal wrist and that the downward curvature of the end of the radius has been re-established. Likewise if reduction is adequate, the roentgenogram will reveal a normal relationship of the styloid processes.

Reversed Colles' fractures can be reduced in a similar maneuver but with a reversal of the forces due to the reversed deformity.

After Care

Because of swelling which may occur, it is preferable not to apply a complete cast, but rather to rely on anterior and posterior splints extending from the elbow to the metacarpophalangeal joints. The position of flexion and ulnar deviation is most generally used and should be maintained for two weeks at which time the midposition, in respect to flexion and extension, may be adopted but the ulnar deviation should be maintained. Daily periods of active motion should be used during the last three or four weeks of immobilization but all support cannot be removed for approximately six weeks from the date of reduction of the fracture.

End Results

Failure to obtain good functional or cosmetic results in Colles' fractures usually is attributable to imperfect reduction, to too long a period of immobilization or to improper splinting. If the fracture is reduced improperly, the distal fragment of the radius unites improperly and a dorsal angulation results which limits flexion of the wrist and weakens flexion of the fingers by causing curves in the line of pull of the flexor tendons. Likewise a radial deviation at the site of the fracture disrupts the radio-ulnar articulation and limits rotation of the forearm. Too long a period of steady immobilization produces fibrosis and adhesions within the joint from which recovery may be incomplete.

Casts or splints should always stop at the distal palmar crease just short of the metacarpophalangeal joints and active motion of the fingers should be encouraged from the start. This fixation will maintain motion of the fingers as well as help to reduce the swelling. Under no circumstances should the fingers be included in the splints or cast of an uncomplicated Colles' fracture. If they are immobilized, stiffness will result and the period of convalescence will be unduly prolonged. During the first few days after reduction, the hand should be observed frequently for swelling in order that all constricting bandages can be released if the retention apparatus becomes too constricting.

Complications

Complications of Colles' fractures are rare. Occasionally they are compound fractures or are associated with fractures or dislocations of the navicular or semilunar bones. The sensory branch of the radial nerve to the thumb and index finger may be injured and lead to a numbness but this usually disappears within a few weeks after reduction of the fracture. Traumatic arthritis may be a late complication and in a few cases a late rupture of the extensor pollicis longus tendon has occurred. The last-mentioned complication supposedly is due to a gradual fraying of the tendon as it glides over a sharp ridge at the site of the fracture.

If the surgeon remembers the normal anatomy of the wrist, secures proper reduction of the fragments, immobilizes the wrist properly and institutes thoughtful care of the patient after reduction, the all too frequent disastrous results of Colles' fractures could be reduced to a minimum.

Worry

As a generality we doctors, in our examinations, deal with work rather than worry, but it is worry that makes people sick rather than work. Worry is related to the person rather than to the fact that there is a cause of worry—ROGER I. LEE, M.D.

Use of the Life Chart in Psychiatric Consultation

By STANLEY COBB, M.D.,* Boston, Massachusetts

The hard-to-diagnose patient may be further studied by the use of one of these charts. Its employment permits recognition of the patient as a human being and points toward detection and possible removal of basic causes of disease.

THE life chart was introduced into psychiatry by Adolf Meyer in the early part of this century[1]. At that time it was a more complicated chart than the one I use, having instead of the central division a graph representing the various organ systems of the body. On this, one could indicate in black and different lesions and incapacities. In the more simplified form used here, this central division is merely left blank and the dark lines across it indicate how much of that year was taken up with illness, each of the horizontal divisions indicating one year's time. An exception to this is at the end of the chart where the years are widened in order to make room for the numerous events taking place. In general, however, the scheme is as follows: In the left hand column there are rectangles in which are written the dates. Similar spaces in the right hand column are filled in with the age of the patient in that year. The wide spaces to the left of the center column are used for medical data and those to the right for social data.

Purpose of the Chart

The object in this schematization is to bring out chronological relations: In any long history taken under the regular headings of chief complaint, present illness, past history, system review, family history, etc., the significant sequence of events may often be lost sight of entirely because the social data are written up with no reference to the medical happenings. So many details may be brought in to each separate department of the history that one does not see the important sociomedical concatenations. These are frequently in time sequences that show on a life chart so it becomes a useful instrument for either abstracting a history or taking down histories at the bedside.

Clinical Technic

In seeing a patient in consultation I usually take one of these blanks to the bedside and, after filling out the age and date columns, I start a conversation that will lead the patient to talk about either symptoms or social troubles and let him follow his own lead unless he needs to be prodded to keep up the flow of facts. Then, as he talks, I put down what happened in a social way in the appropriate space, or if he is talking about symptoms I list these. Often the social history may be taken from the patient at the bedside and the medical symptoms filled in later from the medical record.

As the spaces fill up it often appears that there is a marked relationship between the onset of a disease, its remissions and exacerbations in relation to events in the patient's social, marital, economic and emotional life. If these relationships show up conspicuously, the patient is then asked if he has ever noticed that he has symptoms in relation to any special situation. He may have himself recognized the fact that his symptoms came on with personal troubles or he may be very resistant to this idea. In either case *it is often a help in therapy to convince the patient that there is this possibility by showing him the life chart and then working out with him the details of the individual incidents.* Besides this, it is often a great advantage to an internist, who has been working with a patient for a long time, to have the case summarized in a way that brings out the chronological sequence of medicosocial relations.

Case History

In the case illustrated by the life chart here published, there is a marked relationship between symptoms and social tensions. The patient was a middle-aged

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man who had been fairly healthy as a boy except for some difficulties in eating, nausea, constipation, and subsequent appendectomy. He went through college well, but afterwards took up a job he did not like and at the end of the first year was discharged for inefficiency.

He began to work with his father who was a rather dominating man and shortly afterwards began to have abdominal pain after meals, "sour stomach," eructations, and heart burn. After about a year of such symptoms, the local physician advised an X-ray examination, which showed a definite ulcer in the duodenum. He went on a diet that partially relieved him, worked for a new boss and a remission in symptoms followed. Next year, he once more worked

NAME

HEREDITY: NO EVIDENCE

Hospital #_____

Date: JUNE 1945

YEAR	MEDICAL DATA	SOCIAL DATA	AGE
1906		BORN IN VERMONT	0
1910			4
1914	TONSILECTOMY		8
1916	ANOREXIA		10
1918	NAUSEA CONSTIPATION	MOTHER ILL	14
1922	APPENDECTOMY		18
1924	INFLUENZA		20
1926		GRADUATES FROM COLLEGE	22
1927		FAILS AT FIRST JOB	23
1928	ULCER SYMPTOMS	WORKS WITH FATHER	24
1929	X-RAY POSITIVE	NEW BOSS	25
1930	ULCER PAIN	TROUBLE WITH FATHER	26
1931			27
1932	ULCER SYMPTOMS	MOTHER ILL	28
1933			29
1934			30
1935		JOB OF HIS OWN	31
1936	ULCER SYMPTOMS	MARRIES WIFE LEAVES	32
1937		WIFE RETURNS	33
1938			34
1939	ULCER SYMPTOMS	LEGAL TROUBLE IN BUSINESS	35
1940			36
1941			37
1942	SEVERE RECURRENCE	NEW JOB IN NEW TOWN	38
	PHOBIAS COMPULSIONS	DIFFICULT WORK	
1943	FATIGUE		39
1944		RETURNS TO WORK WITH FATHER	40
	SEVERE RECURRENCE	RETURNS TO JOB IN H...	
1945		WANTS TO GIVE UP JOB	41

under his father and had a slight recurrence. Later he had some more ulcer symptoms when his mother was ill and he was afraid she might die. For the next three years things went well, following which he took a job of his own, married, and assumed more responsibility. Trouble with his wife occurred to such an extent that she left him for a few months. This was coincident with a rather prolonged bout of ulcer symptoms.

Three years later, there was another exacerbation when he had financial difficulties and a law suit about his business. In 1942 he moved to a new town, H . . ., and here had to make new friends and organize a new business along similar lines to the one he had before. He found this work hard and felt lonely. He then began to have symptoms rather constantly and phobias and compulsions with fatigue feelings. In 1944 it was rather a relief to him to return to work under his father, but later, on going back to the old job at H . . . he had an exacerbation of symptoms and wanted to give up this sort of work altogether.

Interviews with this patient showed that he was rather passive. He accepted the advice of others but was sensitive about this tendency and likely to overcompensate in an irrational way. He usually had trouble with his boss, especially when his father was in that role. He never had really liked his work but had been successful enough so that he was afraid to get out and take up anything else. He was not satisfied with himself and felt rather frustrated with life.

Of course one such history means little, but when, in a disease like duodenal ulcer, histories of this kind are found frequently, one begins to be impressed by the role played in gastro-intestinal disease by emotional stresses and strains. For an explanation of this, the reader is referred to the works on psychosomatic medicine,[2] especially the monograph by Wolf and Wolff,[3] which recounts the prolonged observations of a man whose stomach was visible through a gastrostomy wound. Here the physician did not have to rely merely on the time relations of symptoms and environmental stress, because he could see what was happening in the stomach both visually and by chemical tests.

The use of a case of duodenal ulcer to illustrate this method is merely opportunistic. It happens that the last patient presented by me to a clinic on psychosomatic medicine was of this type. Equally impressive charts are found in cases of rheumatoid arthritis, glaucoma, Raynaud's disease, mucous colitis and asthma.[1]

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YOUR HAPPINESS

Happiness broadly consists in the free exercise of one's abilities. The happiness of an adult requires satisfaction of his abilities to enjoy past remembrances and future prospects, as well as fulfilment of his immediate desires. The more complex a personality and the more varied his abilities, the more difficult it is to secure a balance of satisfaction but the more intense and elevated happiness it is possible to attain.—PHILLIP L. ALGER in Scientific Monthly.

Some Common Errors of the General Physician in Dealing with Foreign Body Injuries of the Eye.

By WILLIAM F. MONCREIFF, M.D.,* Chicago, Illinois
Professor of Ophthalmology, College of Medicine, University of Illinois

THE principal errors made by general practitioners in dealing with foreign bodies in the eye or foreign body injuries to the eye may be classified under (1) diagnosis, and (2) management, including after care.

These foreign body injuries themselves may be grouped under certain general headings, namely, those due to (1) direct injury and (2) indirect injury or contusion. In either type the resulting lesion to the eye may be a penetrating (or perforating) or a non-penetrating (non-perforating) injury. At least three-fourths of these injuries are of a superficial and relatively benign type, in which a foreign body of small size is embedded more or less superficially in the cornea or in the tarsal conjunctiva, less frequently in the bulbar conjunctiva, or sometimes, especially in the case of very small fragments of glass, in the retortarsal folds, especially above.

Overlooked Foreign Bodies

In regard to diagnosis, the commonest mistake is failure to discover the presence of the foreign body or bodies, especially those embedded in the surface layer of the cornea or those which are hidden in the retrotarsal folds. Without going into the details of the technic of examination of the anterior segment of the eye, particularly of the cornea, by means of the window reflex or by oblique illumination, which play such an important part in the daily routine of the ophthalmologist, it may be pointed out that the use of a stain, for example, flourescein, is of value in nearly all cases in locating a foreign body in the cornea or an abrasion produced by any type of injury. The site of the foreign body or abrasion, if recent, stains a bright green, and by concentrating focal illumination on this area the presence or absence of a foreign body can be readily determined. Should the foreign body lie in the retrotarsal folds it may have caused lacerations of the conjunctiva and such lesions will also stain with flourescein. (See Pictorial Section, *Clinical Medicine*, Aug. 1945.—Ed.)

Technic of Removal

Assuming that a foreign body is superficially embedded in the cornea and that it has been found, the most common error likely to be made by the general practitioner is unnecessary trauma to the cornea in the process of removing the foreign body with one or another of the sharp spuds which are manufactured for this purpose. Since many of these foreign bodies are only superficially embedded in the epithelial tissue, they can readily be removed, after surface anesthesia with pontocaine, by the use of nothing more complicated than a moist, sterile, cotton-tipped applicator. With this simple method, the cornea can scarcely be traumatized.

Should the foreign body be too resistant to this method of removal, then a foreign body spud must be used. The best type has a sharp, rounded edge, U-shaped in cross section, but not sharply pointed. The sterile spud held in the right hand (in the case of right-handed individuals) is pushed underneath the foreign body to a depth not greater than necessary and the foreign body is then lifted out.

Unless the general practitioner is sufficiently skilled in the use of these instruments, and particularly if the foreign body has caused heat (thermal) or chemical necrosis of corneal substance so that a mass of tough necrotic corneal tissue has to be removed, it is desirable that such cases be referred (whenever feasible) to an ophthalmologist.

After Care

Unless correct judgment is used in the after care of these injuries, many patients with only slight superficial abra-

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sion of the cornea after foreign body removal, and little or no reaction, will be unnecessarily inconvenienced by the use of a bandage, dressing, or patch, or by a cycloplegic-mydriatic, such as atropine. This is not to deny the value or necessity of these measures as well as others, in case of doubt, or if there are complications which require it.

If inflammatory complications of cornea or iris occur, but are mild, homatropine may be substituted for atropine. In a small proportion of cases, some inflammatory process in the cornea, with secondary iritis, occurs after removal of a foreign body from the cornea. Neglect in the proper care of such complications will result at best in additional disability and discomfort to the patient, and at worst in some permanent visual defect, or, in rare cases, loss of the eye.

An important rule in the after care of foreign bodies in the cornea is that *every patient should be seen the day following removal of the foreign body*, and a careful examination made, especially of the site of injury. Should there be signs of any complication, as above noted, the patient should be placed under the care of an ophthalmologist.

Space limitations preclude full discussion of more serious eye injury. However, two important conditions will be noted: (1) the possible result of contusion, such as intraocular hemorrhage, of greater or lesser severity, with hemopthalmos, or merely hyphema. Various complications are possible, one of the most important, and preventable, being secondary hemorrhage, one or more days after the injury. Consequently, such injuries should never be regarded lightly, and immediate hospitalization of the patient, under care of an ophthalmologist, is important. In these cases, full doses of vitamins C and K, and of calcium salts, are essential.

(2) The penetrating injury with retention of an introcular fragment of steel or iron, in which this type of injury is not suspected by the patient, nor immediately obvious on inspecting the eye. The wound of entry, whether corneal or scleral, may be very small and difficult to find, especially for the uninitiated, even though the injury is fresh. The history is of the greatest importance, as such injuries are most likely in mechanics working, without protecting goggles, around metal lathes and other high speed power tools, or in any person who hammers a steel chisel or wedge with a steel or iron hammer, and as a result of explosions. In any such case, roentgenograms are essential.

In conclusion, let it be made clear that the purpose of these remarks is not to cast aspersions on the general physician for his errors in this field, but to warn him of certain difficulties and dangers, and to offer some advice upon how to meet these difficulties.

58 E. Washington Street.

Common Intestinal Parasites and Their Treatment

By C. D. MARPLE, M.D., Los Angeles County Hospital, Los Angeles, Calif.

PARASITIC infestations of the intestine will be encountered more frequently in civil practice as men who have seen military service in areas where such parasites are endemic are released from the armed forces. Such endemic areas include not only the whole of the Orient, the islands of the South Pacific, and the Mediterranean basin, but also large portions of the continental United States, particularly in the southern states.

The medical aphorism that the more numerous the accepted treatments for a given condition, the less effective is any single one, is borne out in the treatment of parasitic infestations. For most of these parasites many drugs have been recommended and almost as many have been found either ineffectual or only partly effective. The following table lists the more common protozoal and metazoal parasites which infest the bowel of man, with one or more satisfactory methods of treatment.

Disease and Parasites	*Drug of Choice and Schedule of Treatment, and Other Effective Drugs*
Amebiasis—(Endameba histolytica.)	For acute amebic dysentery, for acute exacerbations of chronic amebic dysentery, for amebic hepatitis, and for amebic abscess of the liver: Emetine hydrochloride 0.032 gms. b.i.d., or 0.065 gms. once daily, intramuscularly, for six days; concurrently give carbarsone 0.25 gms. t.i.d. orally for seven days; follow carbarsone with either diodoquin 0.6 gms. t.i.d. or vioform 0.25 gms. t.i.d. orally, for 7 days. For asymptomatic "carriers": carbarsone 0.25 gms. t.i.d. for ten days, followed by either diodoquin 0.6 gms. t.i.d, or vioform 0.25 gms. t.i.d., or chiniofon 0.75 - 1.0 gms. t.i.d. orally, for ten days.
Giardiasis—(Giardia lamblia.)	Atabrine hydrochloride 0.1 gms. t.i.d. orally, for 5 days. Acranil has been recommended recently.
Schistosomiasis—(Schistosoma hematobium, japonicum and mansoni.)	Fuadin (Neo-antimosan, stibophen) 1.5 cc., 3.5 cc., 5.0 cc. intramuscularly, on successive days, then 5.0 cc. on alternate days to completion of 10 doses. One may repeat the course after a rest period of one week. Sodium, or potassium antimony tartrate intravenously and anthiomaline (lithium antimony thiomalate) intramuscularly are useful substitutes.
Tapeworm—(Taenia solium T. saginata, Diphylobothrium latum and Hymenolepsis nana.)	Preliminary starvation for 24-48 hours with daily purge of 15.0 gms. sodium, or magnesium sulphate. On third morning give oleoresin of aspidium 0.6 - 1.2 cc. in gelatine capsules, one capsule every half hour for three doses. Follow in half hour with 15.0 gms. sodium or magnesium sulphate. Examine all stools until scolex (head) is found. Successful treatment may necessitate the introduction of the drug by duodenal intubation.
Strongyloidiasis—(Strongyloides stercolis.)	Gentian violet (medicinal) 0.065 gms. t.i.d. orally, in enseals, for 14 days. A 0.5% aqueous solution may be given by duodenal intubation, or intravenous injections may be necessary in severe or resistant cases.
Hookworm—(Necator americanus, Ancylostoma duodenale.)	Tetrachlorethylene 3.0 cc. orally, in gelatin capsules, single dose on an empty stomach preceded, the night before and followed after two hours, by a saline purge. Tetrachlorethylene is highly effective and has a low toxicity. Substitutes include hexylrescorcinol, carbon tetrachloride, thymol, and oil of chenopodium, all more toxic and less effective.
Ascariasis—(Ascaris lumbricoides.)	Hexylrescorcinol crystoids (caprokol) 1.0 gm. orally, in capsules, single dose on an empty stomach preceded, the night before and followed after two hours, by a saline purge. For mixed infestations with ascaris and hookworm, Faust recommends Tetrachlorethylene 2.7 cc. and oil of chenopodium 0.3 cc., single dose with preliminary and subsequent purge. Dose may be repeated after five days.
Trichuriasis—(Trichuris trichiura.)	Hexylrescorcinol as for ascariasis. One may repeat treatment after 1 week. Faust uses tetrachlorethylene 2.7 cc. and oil of chenopodium 0.3 cc. preceded by a high soap enema, the night before.
Pinworm—(Enterobius vermicularis.)	Hexylrescorcinol as for ascariasis. Faust recommends gentian violet (medicinal) 0.065 gms. orally, in enseals, t.i.d. for 8 days. Tetrachlorethylene is also effective.

1200 No. State Street

The Treatment of Subacute Bacterial Endocarditis*

By J. J. WARING, M.D.
Professor of Medicine, University of Colorado, Denver, Colo.

SUBACUTE bacterial endocarditis is an infectious disease occurring in relatively young persons. It usually affects the heart valves damaged by rheumatic heart disease or congenital lesions; caused by the *Steptococcus viridans*, a green-producing, non-hemolytic streptococcus.

Clinical Signs

1. Signs of valve disease, usually in a quiescent stage; often the previous heart damage is not severe. 2. Signs of infection, including fever. 3. Signs of emboli into the conjunctivae, skin and internal organs. 4. Many positive blood cultures.

Blood Culture

The organism should be demonstrated on a number of cultures. Because it appears intermittently, weekly cultures may be necessary to confirm the diagnosis.

Classification of Streptococci Found

1. Pyogenic: Beta-hemolytic, occasionally non-hemolytic. Prognosis: Poor.

2. Enterococcal, fecalis, liquefaciens, zymogenes; poor prognosis.

3. Lactic, alpha or non-hemolytic.

4. Viridans, alpha or non-hemolytic. Prognosis better since advent of recent treatment.

Test Organism for Penicillin Sensitivity:

The organism found in the individual patient's blood can be tested for sensitivity to penicillin, against a standard size dose. This is a gauge of the size of dose needed to treat the patient.

Treatment

The lesions of subacute bacterial endocarditis *tend to heal;* if the infection can be kept down long enough, cure may follow.

Many forms of therapy have been tried, including:

1. *Physical therapy*, (sun lamp radiotherapy of heart, ultraviolet ray).

2. *Surgical*, including: (a) Closure of a patent ductus ateriosus, which has been fairly effective, and (b) splenectomy.

3. *Palliative.*

4. *Chemotherapy.* (a) Arsenic (Neoarsphenamine,) sodium cacodylate, have been recommended but not proven effective. (b) Mercury preparations, including mercurochrome. (c). Dyes. (d) Sulfonamides, which have resulted in some cures. (e). Penicillin, which has also had some beneficial effect.

5. *Biologic* therapy has been ineffective. (a) Transfusions of blood or sera, either whole blood, from immunized donors or recovered patients; (b) vaccines, including living organism inoculation and bacteriophage, have not cured.

The rate of spontaneous recovery is 1 percent.

Causes of Sulfa Therapy Failure

1. Death occurs, due to embolus, or to heart failure, despite sulfonamide benefit as far as the infection was concerned.

2. Rarely, a toxic effect proves fatal.

3. Inefficient penetration of the valvular lesions.

4. Development of resistance by the organism.

5. The organism is a resistant strain of non-hemolytic streptococci.

6. The drug is bacteriostatic, it does not destroy the organism and the body does not develop sufficient immunity.

Ligation of a Patent Ductus Arteriosus

The congenital anomaly, patent ductus arteriosus, is a failure of the fetal vessel connecting the aorta and the pulmonary artery, to become obliterated. The pumping action of the heart drives organisms through the short-circuit, or shunt, into the pulmonary artery. Ligation of the ductus prevents subacute endocarditis and also may cure it. Forty percent of the deaths occurring in patients with

*Clinical Medicine Staff notes taken at a Rheumatic Fever Refresher Course, University of Colorado, June, 1945.

patent ductus arteriosus are due to subacute bacterial endocarditis. A patient with such a ductus at age 17 has an expectancy of only 17 years, if untreated.

Streptococcus Viridans Septicemia

1. Infected congenital heart disease.
2. Infected patent ductus arteriosus.
3. Infected, acquired arteriovenous aneurysm; curable if diagnosed and removed surgically.
4. Infected, acquired arteriovenous aneurysm plus secondarily infected heart valves.

Factors Influencing Recovery

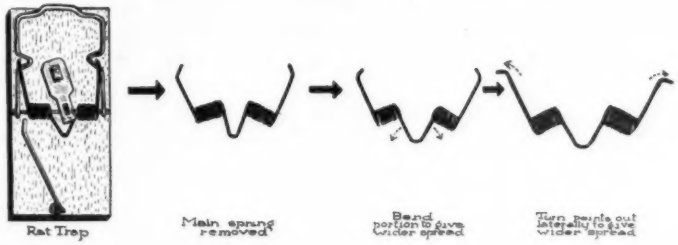
1. Amount of damage to valves, chorda tendinae, septum.
2. Septal failure.
3. Damage to viscera by emboli and mycotic aneurysms; kidney damage.
4. The nature of the congenital heart disease.
5. The resistance of the infecting organism.

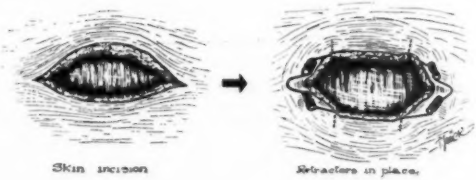
Prophylactic and Curative Measures

1. Prophylactic
   a. Surgical ligature of a patent ductus arteriosus.
   b. Prevention of rheumatic fever will prevent many cases of subacute bacterial endocarditis.
   c. Prevent streptococcal infection in old rheumatic fever patients by; 1. General prophylaxis with sulfonamide. 2. Specific prophylaxis: Give sulfonamide before and after extraction of teeth and tonsillectomy.
2. Curative
   a. Penicillin with or without sulfonamide.
   b. Repeat treatment after emboli.
   c. Appraise the sensitiveness of the organism to penicillin.
   d. The bacteria is most sensitive to penicillin when growing most.

Simple, Inexpensive Retractors

Spring retractors obviate the need for an assistant in retracting skin edges. Frank H. Hodgson, M.D. of Kansas City, Missouri suggests a simple method for manufacturing them: Rat traps (*not* mouse traps) are purchased, the main spring is removed, the spring is widened to give wider spread, the sharp points are turned out laterally and the springs are nickel or silver plated. They are useful in hernia and thyroid surgery, where they expose the field well, yet are covered by the sterile towels. (Clinical Medicine pictorial section; original idea published in *American Journal of Surgery*, March 1946).





Gonorrhea in Women

The diagnosis of gonorrhea in women is often not made during the acute stage and may be more often overlooked than found in the chronic stage.

Error Number One

"My class of patients don't have gonorrhea." Perhaps they are not promiscuous, but their husbands or friends may be.

Error Number Two

"A smear was negative." A negative laboratory finding means that nothing was found in that particular specimen. Were smears taken from the urethra, cervix and Bartholin's glands (see illustrations)? Were smears repeated three times? Were cultures taken? Cultures are much more reliable in the diagnosis of chronic gonorrhea. The secretion is gently rubbed over the surface of the culture medium, which has been previously kept refrigerated, and the plate or tube put in the incubator or mailed to the laboratory.

Error Number Three

"She didn't have any symptoms of gonorrhea." There may be no symptoms resulting from either acute or chronic gonorrhea in women, especially in those who have a chronic vaginal discharge. Acute gonorrhea may cause urinary frequency and burning ("cystitis").

Smears should be spread thinly across

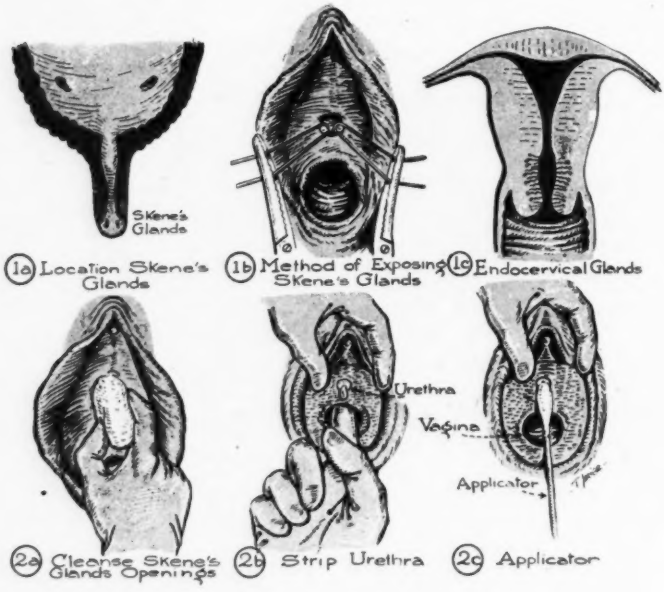


Fig. 1a. Diagrammatic sketch indicating location of Skene's glands. (from Pelouze)
1b. Simple method of exposing Skene's glands (adapted from Greenhill).
1c. Endocervical glands illustrated diagrammatically (from Pelouze).
2a. Skene's glands: Cleanse the urethral meatus with dry cotton.
2b. Strip the entire urethra with the finger, paying particular attention to the lower half inch.
2c. Pass a small cotton-wrapped applicator one-half inch into the meatus and rub it into the floor of the urethra whether fluid can be seen or not.

the slide so that they may be studied easily, under the microscope.

In women there are *two* decidedly frequent areas of residual infection: Skene's glands in the urethra and the glands in the cervix. Bartholin gland infections are less common but important.*

Axioms

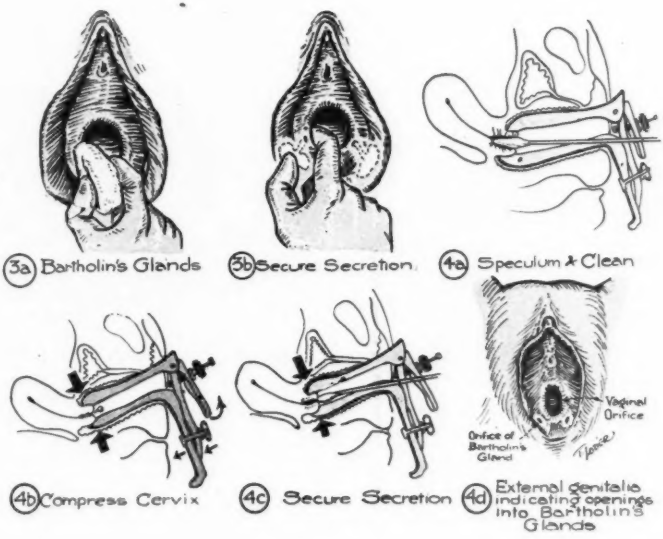
1. Gonorrhea in women is commonly in a quiescent state at the time of study.

2. No laboratory report can be better than the material supplied.

3. Quiescent gonorrhea is essentially a disease of the smaller mucous glands whose secretions must be obtained if gonococci are to be found (Skene's, endocervical, Bartholin's).

4. Surface fluids from the vagina or vulva in the adult, except in the unusual fulminating case, are practically useless for study.

*The U.S. Public Health Service have published a very valuable booklet, "The Diagnosis of Gonorrhea in Women," written by P. S. Pelouze, M.D., from which, by permission, a number of quotations and redrawn illustrations, have been taken.



3a. Bartholin's glands: Clean the opening of Bartholin's duct, at the junction of the middle and posterior third of the labia minor, with dry cotton.

3b. With a finger in the vagina and the thumb externally, compress the intervening structures and collect even the slightest moisture for study. The quantity obtained is so slight that it is lost in a cotton-tipped applicator. Use a platinum loop or the flat end of a toothpick, to obtain the secretion.

4a. Introduce a wet vaginal speculum (use no lubricant which will become smeared over the cervix), so that the uterine cervix rests between the ends of its blades and remove the cervical plug of mucus by cotton-wrapped applicators or a suction apparatus.

4b. After cleaning the cervical canal, compress the cervix by squeezing the blades of the speculum upon it, so that secretion is forced out of the glands.

4c. Secure the secretion on cotton-wrapped applicators.

4d. The external genitalia, indicating openings into Bartholin's glands and the urethral meatus (adapted from Williams).

Hemorrhoidectomy by Incision and Dissection

RAKOV* has described a modification of Pennington's technic for Hemorrhoidectomy. "The essential difference between this type of operation and the usual procedure is that it consists of an incision and dissection of the hemorrhoidal tumor rather than an excision of the tumor and its covering en masse."

Anesthesia: Spinal or parasacral (caudal could be used—Ed.) causing anal sphincter relaxation and exposure of all lesions.

Operating Table: The table is "broken" so that the patient is flexed, and the hips are uppermost.

* Rakov, Capt. Philip H., MC, Army of U. S.: Hemorrhoidectomy by Incision and Dissection. *Am. J. Surg.* 68:73-76 (April) 1945.

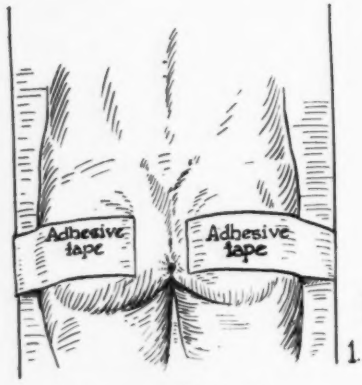
Operative Technic: Fig. 1. Adhesive straps fastened to the side of the table hold the buttocks apart.

Fig. 2. Three hemorrhoids, two being external, the upper right internal, as shown by the skin margin.

Fig. 3. Each hemorrhoid is grasped separately, an Allis forcep being used to pick up the skin and a Kocher forceps the mucosa. The line of proposed incision is indicated by the dotted line.

Fig. 4. The hemorrhoid is thus held taut and is incised deeply, after which the edges of the incision are caught with Allis clamps. The index finger everts the hemorrhoidal venous plexus by pressure from below.

Fig. 5. The hemorrhoidal plexuses are



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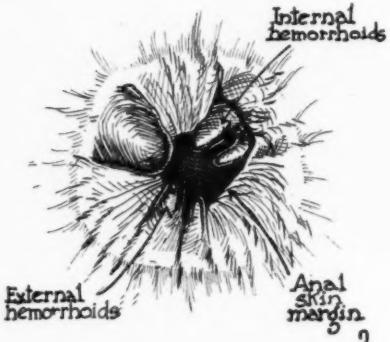

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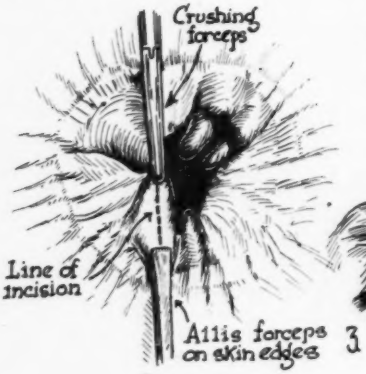

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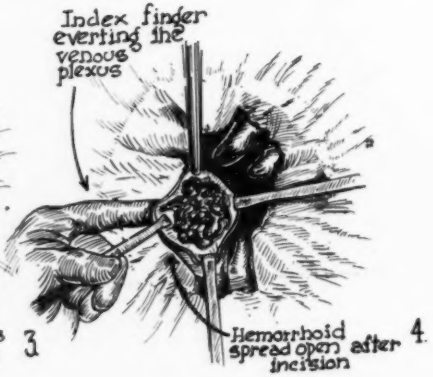


4.

removed with curved scissors, by pressing the convex surface of the opened blades against the bulge, made by the upward pressure of the index finger, and cutting the tissue which is forced between the blades.

Fig 6. End result after removal of all hemorrhoidal tissue by three incisions and dissections of adjacent flaps. Small adjoining hemorrhoids may be enucleated through the nearest incision by dissecting back the mucosa.

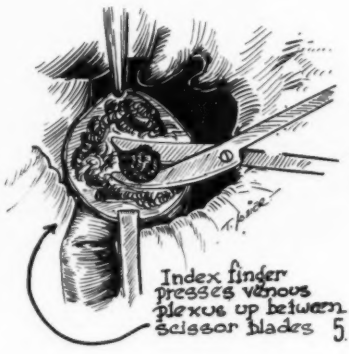
An assistant may grasp hemorrhoidal tissue with toothless thumb forceps so that it may be snipped away more easily. The other half of the incision is then dissected in a similar manner.

Bleeding: Minute arterioles are clamped and tied with fine cotton.

Removal of excess skin or mucosa: If the flaps are redundant, a crushing clamp, such as an Ochsner, may be applied and the excess cut away (if postoperative pain is to be avoided, why crush tissue? Why not cut off excessive tissue with scissors immediately after step 5?—Ed.)

Sutures: None; the wounds are left open for drainage, thus avoiding postoperative abscesses and cellulitis.

Postoperative Care: A vaselined strip of gauze is placed over the area and a pressure dressing of gauze and cotton-waste applied. The patient is allowed out of bed after 24 to 48 hours (patients who walk around immediately have fewer complications, such as postoperative retention of urine, and less pain—Ed.), at which time sitz baths are begun.



5.

Appearance immediately after operation 6.

Early Symptoms of Gastric Cancer

Early diagnosis of gastric carcinoma may be made by:

1. Being alert for early symptoms of disturbed physiological processes, reversal of peristalsis as indicated by *fullness* or *burning* after meals, or *belching* occurring in a patient who was previously free of it.

2. By noting the patient who has gone on a self-prescribed diet for months and who has reduced the amount of food taken at meals (such a patient may not consult a physician until the dyspepsia is a daily event in spite of his diet).

3. By asking about *decrease of appetite and slight nausea*, which are due to disturbances in gastric motility and proper direction of food flow.

4. By finding that the patient *feels full* after eating less than the customary amount of food.

Eventually *nausea*, periodic or continuous, becomes so annoying that the patient voluntarily restricts his diet. Soda or an "ulcer management" frequently relieve all symptoms of gastric cancer until too late.

All the above symptoms occur before epigastric pain, weight loss and anemia appear.—A. C. CLASEN, M.D., in *Hawaii M. J.*, July-Aug. 1945.

EDITORIALS

Why Study?

The young physician is encouraged to study diligently, by some persons, in the hope and expectation that by knowing more he will reap a larger practice. This is reminiscent of the Sunday school circulars that told us to be good because the "good" boys and girls achieved material success, and is about as relevant.

It is not unethical to desire a large practice nor to study persistently so as to be ready for the increasing number of patients. It is unfortunate however that the connotation of study and money is made. This encourages the young physician to take short courses in profitable subjects instead of grounding himself in diagnosis and general treatment.

The young physician who feels, after a year or two of practice, that medical school has given him enough of a foundation for the general practice of medicine and that he only needs to read a few journals to learn the new things, is a menace to his patients. He learns a rapid technic for appendectomy but has to ask the detail man what form of digitalis is most popular. He injects hemorrhoids and forgets to use a sigmoidoscope first, to rule out a cancer which may have caused the hemorrhoid. He makes snap diagnoses and writes three line histories.

If the physician does not honestly enjoy the study of medicine, he should go into hospital administration (a profitable and neglected field, by the way), insurance or other medical executive work. Today, he *must* keep up with the new and constantly review the old.—R. L. G.

Heredity determines what one can do, environment determines what one does do.—J. M. Cattell.

There Are Plenty of Fascists

"One thing, and one thing alone unites all individual Fascists: In one way or another, fascism solved each one's personal problem, or seemed to solve it, or promised to solve it, *at the expense of someone else.*" (Percy Winner, *Harpers*, October, 1945)

With the toppling of the fascist governments of Germany and Italy, it is easy to delude ourselves in the belief that the fascists and their views are no longer to be reckoned with, in Europe.

As Winner has so well written, the circumstances that drove huge numbers of Europeans into support of fascist governments may again force the masses of little, frightened people to become slaves to a giant party.

There are plenty of fascists in this country, too. Those who want to take from one person and give to another are always popular, with those who hope to receive. Greedy races and greedy groups provide convenient targets for politicians and other self-appointed leaders. We all must beware the person who hopes to advance by condemning others.

Educating Your Patient: Smoking

For the patient who wishes to know if he should smoke, for the pregnant woman who "can't get along without her cigaret," for the high school and college students, who are just taking up smoking even for the physician who smokes, Steinhaus has written a leaflet "Shall I Become A Smoker?" •

He compares scientific advice to a road map. The road map does not care whether you go to New York or San Francisco; science does not care whether you smoke or not. Both give you information you need to know in making up your mind.

This is modern language at its best, from a standpoint of good writing as well as a very brief scientific explanation of what smoking does to the body.

•Arthur Steinhaus, Professor of Physiology, George Williams College, Chicago, Illinois. Published by the National Education Association, 1201 Sixteenth Street, Northwest, Washington, D. C. 12 leaflets for 25 cents (nonprofit basis).

Resuscitation

The saving of life is the most important and most satisfying of the physician's duties. Every physician regardless of his specialty sooner or later finds himself in a situation where immediate action must be taken to save a life. He must know how to carry out this action *himself* rather than to depend on a voluntary rescue squad, fire department, or other lay groups.

Our record in the past has not been too good, and in a few cases, a physician has stopped a well-trained team who were carrying out artificial respiration in the proper manner, just for the purpose of giving a stimulant hyperdermically. Even if the stimulant were dramatically effective. and research indicates that very few are, it would need to be given intravenously.

Whatever the technic used is less important than the determination of the physician and his substitutes to stay with the attempts of resuscitation for several hours as a minimum. Illustrations were given showing the technic of various methods of artificial respiration. The simplest method over a long period of time is Eve's Rocking Method; until a board or door can be obtained on which to rock the patient, he may be tilted by two men or may receive Schafer's method.

In a recent symposium in *Clinical Medicine* it was agreed by the anesthetists consulted that the use of the oxygen, breathing bag and face mask was very effective. The bag was compressed by the hand rhythmically and the mask held snugly against the face, thus inflating the lungs.

As is often the case, minute details have been exaggerated until most laymen and many physicians feel that artificial respiration must be given at very regular intervals. It is true that a regular rhythm should be imitated, but not to the point of burdening oneself with intricate counting, and neglect of the patient's first attempts at respiration.

The simplest method and one that may be used when the patient is lying on his back, is mouth to mouth breathing. For some reason physicians seem to be quite concerned about the possibility of introducing bacteria into the respiratory tract. The fact that all of us are continually inhaling contaminated air seems to be overlooked. Even more important is the fact that the patient would rather be alive and in possession of a few organisms rather than to be dead in a sterile manner.

At this time our chief efforts in heart respiration are directed toward the restoration of breathing. First, because in most cases the heart goes on beating long after respiration has ceased. Second, there are very few efficient cardiac stimulants. Third, it is much easier to effect respiration. Fourth, changes in the thoracic cavity pressure increase the volume of blood returning to the heart, thus indirectly stimulating it.

On one occasion a very fat woman was undergoing an abdominal procedure under a spinal anesthesia, when respiration and circulation stopped suddenly. The nurse was instructed to grasp the tongue and hold it up out of the throat. One of us made regular compressions of the chest wall and the other squeezed the heart between one hand on the precordium and the other up against the diaphram. Within a minute the patient was breathing normally and the heart had resumed beating.

On a number of occasions it has been necessary to interrupt surgical procedures or deliveries to employ a few moments of artificial respiration. Many surgeons are reluctant to contaminate their sterile gloves and gowns, thus delaying a few precious moments while a nurse or interne is attempting to compress the chest. I believe that every physician should fight for his patient's life, and not give up the struggle until every resource has been exhausted. I believe that every physician should know a few simple methods that can be applied anywhere, and have the initiative, knowledge and determination to step in and care for an emergency to the end.

The saddest words of tongue or pen are: "'Nothing more can be done for him."

The conditions of success in life are the possession of Judgment, Experience, Initiative and Character.—GUSTAVE LE BON.

CLINICAL NOTES AND ABSTRACTS

Pernicious Anemia

Pernicious anemia usually occurs after the age of thirty. There is usually no important loss of weight, the tongue is smooth and often red, the liver is markedly enlarged, the red bone marrow is increased and is soft and deep red in color. The onset is so slow that the patient cannot tell when he first noticed weakness.

Weakness is often the first symptom, but indigestion may be noticed first in about one-third of the cases. Distress from gas and mild intermittent diarrhea, as well as constipation, are common. Gallbladder disease is frequently associated, Persistent and symmetrical numbness, and tingling of the hands and feet may appear before typical changes occur in the blood studies. Vibration sense is decreased, especially in the lower legs which is easily detected by the use of a tuning fork on the tibia. Later, a loss of sense of position may occur, and, still later, flaccid and spastic paralyses.

The red blood cells are reduced to a greater extent than is the hemoglobin. Smears show a variety of nucleated red blood cells. The white cells, and particularly, the platelets, are decreased in number. The history of the patient, the tuning fork and the stomach tube, which indicates a lack of acid in the stomach, are often almost as important in diagnosis as a well-stained blood smear. If both liver and iron have been given prior to blood studies, it is impossible to decide, without temporarily stopping treatment, whether or not liver therapy is necessary for the rest of the patient's life.

A dose of 15 units of liver extract every two weeks suffices for most cases after the blood has been raised to normal. Liver extract therapy must not be stopped. It is even more necessary to the patient with pernicious anemia than is insulin to the diabetic.—GEORGE R. MINOT, M.D., in "The Doctors Talk It Over" (Lederle Laboratories)

Treatment of Menopausal Symptoms

Methyltestosterone is a safe, effective means of controlling menopausal symptoms, and of somewhat greater benefit than stilbesterol. For the small number of menopausal women who require endocrine therapy, we have urged the use of testosterone rather than estrogens for:

1. Patients who have been treated for cancer of the reproductive tract or breast.

2. Patients who have been treated for abnormal uterine bleeding or who have developed bleeding while taking stilbesterol.

3. Patients who require endocrine therapy for vasomotor symptoms.

4. Patients who have become addicted to stilbesterol.

—S. B. GUSBERG, *Am. Jour. Ob. & Gyn.*, Nov., 1945.

Penicillin for Local Application

Penicillin for local application should be in a watery, low potency solution. As penicillin acts only when its solution is in direct contact with the organism concerned, it must be applied in a form which is readily miscible with any exudate present, which will diffuse readily into the skin and surrounding tissues and penetrate well into the ramifications

of the lesion. An ointment fulfils none of these criteria, a watery solution all of them.

Cases which are helped by local application include impetigo, sycosis, boils, carbuncles, conjunctivitis, septic wounds, burns, compound fractures, osteitis, empyema, chronic ulcers and, very slightly, sinusitis. The penicillin used is an aqueous preparation, containing 20 units per 1000 cc. buffered at pH 6.5 and stabilized by the incorporation of one part per million of merthiolate.

The main point is to maintain an active concentration and therefore the potency of the solution used is of minor importance, in comparison with the frequency of its renewal. A solution twice as potent will not necessarily maintain this required concentration for twice as long, nor will it affect bacteria any more quickly or surely. In these cases the local applications should be applied at least every three hours, preferably as a wet dressing. R. G. SHUTTLEWORTH, Cape Town, South Africa in *Clinical Proceedings Cape Town Post-Graduate Med. Assoc.*, Sept. 1945.

Parenteral Saline Solution Postoperatively

Parenteral saline solution given postoperatively is retained in the body with a large percentage going to the wound tissues, resulting in edema and delayed wound healing or even wound disruption. In experimental animals, saline solution administration causes a delay in wound healing. Such solutions should *not* be given routinely, but only on definite indications. — WILLIAM MCDOUGAL, M.D. (Butterworth Hospital, Grand Rapids, Michigan) in *Am. J. Surg.*, Mar. 1946.

Nasal Fissures

Nasal cracks or fissures are a form of dermatitis of the nasal vestibule and are accompanied by pain, redness, excoriation and crusting. The interior of the nose should be searched for the presence of undue secretion such as is seen in purulent sinusitis and allergic states. It is these states that are thought to be the underlying causes of the vestibulitis.

The treatment of the fissures themselves consists in applying silver nitrate solutions in varying strengths (5 to 20 per cent) and then following with applications of a mild ammoniated mercury ointment (2.5 to 5 per cent). Instead of silver nitrate, some advocate the use of stronger caustics such as trichloroacetic acid (50 to 90 per cent). Lastly, the actual cautery may be tried in the more stubborn instances in which granulations have arisen on the borders of the fissures. The underlying sinisitis or allergic state should receive attention.—*J.A.M.A.*, March 16, 1946.

Pancreatic Cancer

The association of dyspepsia, loss of weight, or obstructive jaundice, with or without pain, with negative x-ray and gastroscopic examinations, should always suggest the possibility of pancreatic cancer. Early diagnosis permits the removal of the head of the pancreas and the duodenum.

Ferment and alkalinity studies of the duodenal secretion by means of a double-lumen duodenal tube, following vagal stimulation with insulin, secretin or mecholyl, helps to differentiate painless jaundice due to common bile duct lesions, from those caused by cancer of the pancreas.—A. C. CLASEN, M.D. in *Hawaii M.J.*, July-Aug., 1945.

Quinacrine for Malaria

Both plasmodium vivax and P. falciparum infections may be cured by quinacrine treatment.

O.2 Gm. of quinacrine is given orally or intramuscularly at the time of diagnosis, followed by O.2 Gm. doses at four-hour intervals until a total of 1.0 Gm. has been given in one day. O.1 Gm. is then given three times daily for seven days.

Intramuscular injections are needed in acute falciparum malaria or those accompanied by nausea and vomiting. It is as rapid as intravenously administered quinine and is free of quinine's toxic hazards.

In such severe cases the initial intramuscular dose is 0.4 Gm. of quinacrine, given half into each buttock. Then 0.2 Gm. given at eight hour intervals

until 1.0 Gm. has been given, followed by 0.2 Gm. at twelve hour intervals until all therapy, consisting of 0.1 Gm. three times a day, is begun.—JAMES A. SHANNON, M. D., *Bull. New York Acad. Med.* Nov. 1945.

Rabies

Dogs, horses, skunks, cats, foxes and other domestic and wild animals carry rabies. Diagnosis in the animal: Any dog showing paralysis, especially of the jaw muscles, drooping of the eyelids, difficulty in swallowing, or a change in personality, should be isolated under a veterinarian's observation for ten days. The decision as to treatment of the exposed human being should first depend on the veterinarian's clinical diagnosis.

The virus is excreted in the saliva. Ingestion of milk or meat from rabid animals is not a source of infection. Contact between infected saliva and unbroken mucus membrane should be considered as an exposure, since the virus is not present in the saliva until the animal has early symptoms. Any bite occurring a week or more before the animal develops rabies does not constitute an exposure.

The virus travels on the sensory nerves to reach the brain and spinal cord. Bites in the areas having the most sensory end organs, specifically, the hands, face, head and neck, are the most dangerous.

Treatment should be begun under the following conditions:

(1) When the dog shows clinical signs of rabies.

(2) When the animal is killed or dies and the brain is found positive by microscopic examination.

(3) When the animal is killed or dies and is negative by microscopic examination but the animal is suspected of being rabid because subsequent inoculation of brain may produce positive reaction.

(4) When the bite is by a stray dog which escapes, provided rabies is present in the community. If the animal appears normal, vaccine may be withheld while the dog is observed for symptoms of rabies.

The wound should be treated by a thorough cleansing and flushing with green soap and water. The dosage of the vaccine averages 2 cc of a 5 percent emulsion. In patients with extensive bites of the head and neck, we recommend two doses daily for seven days . . . then one dose daily for fourteen additional days. Wounds on the trunk or extremities may be treated by fourteen doses . . . given one each day.

Reactions do occur. If general symptoms of headache, fever, nausea or general malaise develop during the course of treatment, careful consideration should be given to the question of whether or not such treatment should be continued. —By KARL HABEL, M.D., in "The Doctors Talk It Over" (Lederle Laboratory, December, 1945)

Transient Tachycardia

By transient tachycardia is meant a heart rate of one-hundred or over of sinus origin, which was followed after rest, on any particular examination or at a later examination, by a rate under 100. Tachycardia was considered to be sustained when a rate of one-hundred or over persisted, in the recumbent posture, throughout one examination or several examinations made in the course of several days.

Transient tachycardia due to emotional disturbance or some other cause not discernible, like transient hypertension of similar origin, is often a precursor of hypertensive vascular disease. In this respect the two conditions are of equal importance. —P. D. WHITE, M.D., in *J.A.M.A.*, Oct. 27, 1945.

Atypical Pneumonia Due to Parrots and Pigeons

Pneumonia due to psittacosis or ornithosis may be differentiated from ordinary atypical pneumonia by its frequent chills, common gastro-intestinal symptoms, severity of illness despite relatively small degree of pulmonary involvement and slight respiratory distress, considerable mental disturbance and a more prolonged and higher degree of fever. The complement-fixation test is useful in establishing the diagnosis as the history of contact with parrots or of pigeons, but positive evidence of

specific infection depends upon the isolation of the virus from the patient and the demonstration of increasing antibody response to the illness.

Penicillin is useful in treating psittacosis and ornithosis. Sulfonamides are not.

Parrots and pigeons have been found to contain virus in a large percentage of cases.—Heilman and Herrel (*Proc. Staff Meetings, Mayo Clinic*, Apr., 1944); Parker and Diefendorf (*Proc. Soc. Exp. Biol. Med.*, Dec. 1944); Turgasen (*J.A.M.A.*, Dec. 1944); Flippen Gaydosh and Fittipoldi, (*J.A.M.A.* May, 1945.

Acute Gastric Hemorrhage

Introduction of the duodenal tube into the stomach for lavage with warm saline solution and aspiration of blood until the stomach is free from old blood, is recommended. If after the stomach is empty, bright red blood continues to return through the tube, this should be taken as evidence that bleeding is still active, probably arterial, and indicates immediate operative relief.—E. H. Risley, M.D., *J. Maine Med. Assoc.* May, 1945.

Physical Methods for Septic Conditions

The routine treatment of septic conditions may be divided as follows: In the first, or acute stage:

(a) Rest, by extensive immobilization, with elastic adhesive tape or Plaster of Paris;

(b) Local heat by means of low intensity diathermy;

(c) Active movement, if possible, of other parts of body;

(d) Improvement of general condition by small doses of ultraviolet radiation.

Second Stage: (Resolution)

Slough separate, the acute symptoms regress and danger of spread is decreased. Treatment is by:

(a) Rest by immobilization of the affected part only;

(b) Local heat;

(c) Active movement, if possible.

In the third stage, or the stage of repair the slough and necrotic tissues have been expelled and granulation begins. The treatment includes:

(a) Ultraviolet radiation. 4th degree doses to the raw areas once or twice a week;

"Psychotherapy or no psychotherapy, I don't like Dr. Benson's bedside manner!"

(b) Packing and dressing with cod-liver oil;

(c) Discard of rigid splinting, provided movement does not interfere with proliferation;

(d) Active movements.

Fourth Stage: (Restoration of Function)

(a) Heat in suitable form to increase local temperature and produce hyperaemia by diathermy, radiant heat or wax baths;

(b) Exercises and occupational therapy to promote movement.

Edema, which constitutes a great hindrance to repair processes and also to mobility, can be controlled by means of massage, elevation of the limb, faradism under pressure, or firm bandaging, with crepe bandages, or elastic adhesive.—By DR. P. BAUWENS in *Proceedings Royal Soc. Med.*, Aug., 1945.

Premenstrual Distress

During the premenstrual phase, sodium is retained by the tissues due to the action of the sex steroids.

This retained sodium holds water in the tissues, resulting in edema. Edema of the intestinal tract causes nausea and abdominal distention, edema of the brain causes migraine or headache, edema of the subcutaneous tissues causes swelling of the ankles.

The use of ammonium choride tablets (30 grain daily) for seven days preceding the premenstrual phase, and avoidance of table salt (sodium chloride), sodium bicarbonate or sodium bromide often relieves the edema and symptoms.

Freed has demonstrated that oral methyl testosterone, in doses of 10 mg. daily for the seven days preceding the premenstrual phase, will relieve the symptoms.

Plaster Treatment of Burns

A one-layer "specialist" plaster of paris dressing, wet in normal saline and snugly held by a plain bandage, offers many advantages in the treatment of burns.

1. It gives immediate relief from pain.

2. It can be removed painlessly. It does not adhere to anything but hair or suture material and does not require grease.

3. When applied frequently, normal skin, inflamed skin, and granulating areas look pink and soft.

4. It affords a good means of using sulfanilamide powder, or any antiseptic, if it becomes necessary.

5. The dressing is inexpensive, and is easily and quickly applied under any condition.—JOHN R. GREEN, M.D. (Independence, Missouri) in *Southern Med. J.* Dec., 1945

Demerol for Painless Delivery

In both primiparae and multiparae, administer early in labor 1½ to 3 grains of seconal or nembutal by mouth, followed by the intramuscular injection of 100 mg. of demerol and 1/150 gr. of scopolamine as soon as the pains become severe and the cervix is dilated 3 or 4 cm. Within twenty minutes after the intramuscular injection, analgesia becomes effective and lasts two to three hours, at which time the demerol, with or without the scopolamine, may be repeated.

The doses may have to be repeated to give sufficient analgesia to carry to the final stage of delivery. With primiparae the dose of 100 mg. of demerol and 1/150 gr. of scopolamine may need to be repeated one or two more times for similar relief, in the usual longer labor.

In multiparae, there is more rapid relaxation and dilatation of the cervix and labor progresses more rapidly. The babies do not have respiratory depression. Tablets by mouth do not have proportionate effect.—HOMER M. CARTER, M.D., Madison, Wis., in *Wisconsin M. J.*, Dec. 1945.

Nocturnal Leg Pain

Night cramping pain occurs in young men as well as in older people. Static foot deformity appears to be the most frequent predisposing factor. Apparently healthy persons may have night cramps and a physical examination may fail to show any defect in circulation or in structure. Quinine sulphate offers rapid and frequently complete relief for varying periods. Doses used are 0.32 Gm., one dose at night before retiring.—JOSEPH H. NICHOLSON, M.D. *The New England J. of Med.* Nov. 8, 1945.

Don't Change That Dressing

Dressings should only be changed when pain or fever appears. "Every change of dressing, even under the most favorable conditions and with the best aseptic technic, means introduction of infection; when conditions are not ideal, the danger is greatly increased."

"Most patients consider that a surgical dressing is evidence of careful medical attention . . . To remove an unsightly dressing and apply a clean, firm, fresh one pleases most patients and *too many physicians.*"—P. S. FOISIE, M.D. in *New Eng. J. Med.*, Mar 7, 1946.

[The temptation to look at a surgical wound is almost irresistible at times, but the physician should remember that *a dressing does not heal a wound* but often may injure the delicate process of healing and introduce infection—Ed.]

Clinical Medicine's illustration shows various sources of infection each time a dressing is changed: 1. and 2. bacteria from nose and throat of patient and physician. 3. physician's fingers. 4. unsterile instruments. 5. gauze dressings. 6. air containing infectious material from other persons. When a dressing is changed or *any* operation performed, all persons in the room should wear masks; instruments and gauze should be sterilized and fingers should not be used to palpate the wound edges. Gauze should be picked up and applied with a forceps kept in antiseptic solution.

Laboratory Diagnosis of Nutritional Deficiency

The clinical diagnosis of nutritional deficiency is still most important, as in many instances the laboratory diagnosis is impossible or difficult. "Normal" values of blood or plasma vitamin levels are difficult to set. Saturation tests with a vitamin are not diagnostic because a state of unsaturation does not of itself imply deficiency.

These tests may make some contribution to the diagnosis of a patient with nutritional disease:

I. IN FRANK NUTRITIONAL DISEASE

Suspected Deficiency	Tests Suggested
1. General	1. Hemoglobin, color index, red cell count, etc.
2. Protein	2. Plasma or serum total protein and albumin.
3. Vitamin A	3. Plasma, vitamin A, and carotene.
4. Vitamins B	4. Urinary excretion of thiamin and riboflavin. Urinary test dose excretion of nicotinamide, methochloride; glucose tolerance test with simultaneous determination of pyruvic acid in blood.
5. Vitamin C	5. Urinary test dose excretion of ascorbic acid.
6. Vitamin D	6. Serum alkaline phosphatase, serum calcium and phosphorus.
7. Vitamin K	7. Plasma prothrombin level.

II. IN MILD OR SUSPECTED DEFICIENCY

1. General	1. Hemoglobin, red cell count, color index, etc.
2. Vitamin A	2. Plasma, vitamin A, and carotene.
3. Vitamins B	3. Urinary test dose excretion of nicotinamide methochloride.
4. Vitamin C	4. Urinary test dose excretion of ascorbic acid.

—DR. L. GOLDBERG, in *Clinical Proceedings Cape Town*, Feb. 1946.

Nerve Injury

Any tissue injury may involve a nerve. *Indirect trauma:* 1. Sudden stretching; 2. compression by tourniquet, plaster, crutch; 3. compression by callus after fracture or by scar tissue; 4. dislocation of a major joint; 5. malposition of extremity during anesthesia, squatting or sleeping.

Direct trauma: 1. Wounds caused by bullet, shell fragments, knife, glass or other sharp objects; 2. crushing wounds of extremities; 3. injuries during surgical operations.—R. A. GROFF, M.D. in "Manual of Peripheral Nerve Injuries" (J. B. Lippincott Co.)

THUMBNAIL THERAPEUTICS

Sulfathiazole Film for Impetigo

Sulfathiazole in an alcoholic plastic vehicle is very effective in the treatment of impetigo. It dries rapidly, does not require a bandage, limits the spread of infection and slowly releases the sulfathiazole into the exudate.—R. H. DRAEGER, M.D., in *J.A.M.A.*, Aug. 11, 1945.

(Prof. F. V. Worman, Adams State College, Alamosa, Colorado, originator of this film, has been treating over 500 impetigo patients.—Ed.)

Undernourished Patients

In undernourished patients, we use small doses of protamine zinc insulin before breakfast and supper. Patients often gain three to six pounds per week. —L. F BARKER, M. D., *"Time and the Physician."*

Vertigo, Meniere's Disease

It is optional as to whether one uses histamine in 0.8 per cent KCl or 0.9 per cent NaCl in the treatment of acute Meniere's disease. It does seem as if the possibilities for improving hearing are greater with the KCl solution.

From the standpoint of the treatment of vertigo, itself, patients respond just as well with the use of histamine in NaCl as in KCl.—BAYARD T. HORTON, M. D., Mayo Clinic.

Breast Treatment

Endocrine therapy with corpus luteum hormone (progasterone injections) is indicated in mastodynia, in selected cases of adenosis and may prevent recurrence of cystic disease.

Estrogenic therapy (stilbestrol, Theelin) relieves painful engorgement of the bbreast in the puerperium.—C. GESHICKTER, M.D., in "Diseases of the Breast." (J. B. Lippincott Co.).

Penicillin Prolongation by Chilling

Chilling the area in which penicillin is to be given for 2 hours preceding the injection and for 12 hours thereafter permits a prolonged action from a single injection.—G. J. THOMPSON, M.D., in *J.A.M.A.*, Mar. 9, 1946.

Quieting the Stomach

During digestion, gastric peristalsis is not as marked as during hunger. The stomach can be put at rest, not by fasting but, by frequent small meals. —S. A. PORTIS in "Diseases of the Digestive System" (Lea & Febiger, Publishers).

Gonorrhea

Those patients who are not cured by 100,000 units of penicillin and a second course of 200,000 units should have a urologic examination to rule out complicating factors (small urethral meatus, urethral stricture, prostatitis).

500,000 units are given to the few remaining patients and cure is obtained in all, in both anterior and posterior urethral gonorrhea. — DONALD PILLSBURY, (Colonel, M.C., A.U.S.) in *Am. J. Syph.*, June 1945.

Face Wounds

Routine wound excision has no place in facial surgery. That same copious blood supply, which in face wounds is often responsible for profuse and even dangerous hemorrhage, will often ensure the viability of flaps almost completely detached and is responsible for the rarity of serious spreading infection. Gas gangrene is unknown.

"Surgery of Modern Warfare" edited by Hamilton Bailey (The Williams & Wilkins Company).

DIAGNOSTIC POINTERS

Cyanosis in Babies

Cyanosis in infants may be due to diapers which have been stamped with ink containing aniline dye.

Prevention: A preliminary laundering prevents such dye poison.

Symptoms: Cyanosis, difficulty in breathing, anorexia, reduced intensity of cry.

Treatment: Tranfusions of whole blood or red cells suspended in saline solution, fresh air or oxygen, and removal of the diapers. — JULIAN GRAUBARTH, M.D., in *J. A. M. A.*, Aug. 18, 1945.

Allergic Headache and Fatigue

Fatigue may be a symptom of an allergic reaction, rather than a psychogenic manifestation.

Severe headaches, even with stupor, may occur as an allergic reaction to milk, beef or other food. Skin tests are often negative. Elimination diets (removal of all foods, then adding one at a time, at five day intervals) indicate the causative foods.—T. G. RANDOLPH, M. D., in *J.A.M.A.* Oct. 14, 1945.

Dental Caries and Candy

Lemon drops, all day suckers and other acidified candies containing citric acid destroy the enamel of teeth, both chemically and experimentally. —I. SCHOUR, D.D.S., in *J. Am. Dental A.*, Aug. 1, 1945.

Large Clavicle

The heavy clavicle of prenatal syphilis should arouse suspicion and call for a thorough physical and serologic examination. — JOHN H. STOKES, M.D., in "Modern Clinical Syphilogy" (W. B. Saunders Co.)

Gastric Retention

If gastric retention is suspected, have the patient eat 50 raisins at 10 p.m. the night preceding gastric analysis with seeds, currants, some uncooked rice or 6 dried prunes. The finding of *many* seeds or prune shreds is an indication of a serious gastric delay. — H. NECHELES, M.D. in *Diseases of the Digestive System* (Lea & Febiger, Publishers).

Vaginal Discharge

Profuse leucorrhea, with irritation of the vaginal mucosa and the skin of the vulva, is not uncommon during the weeks or months following confinement. Trichomonas infection should be suspected as the cause for this and examination made microscopically for the organisms. —From "The Management of Obstetric Difficulties" by PAUL TITUS (C. V. Mosby Company).

"Gallbladder" Symptoms

The symptoms of so-called "gall bladder indigestion" are the same as those due to indigestion from any other cause. —ROSCOE PULLEN, M.D. in "*Medical Diagnosis*" (Saunders).

Fatigue in Pregnancy

Lassitude, irritability, apparent anemia, a tendency to increased weight, or a pulse below 60 per minute suggests thyroid deficiency in pregnancy. Basal metabolism determinations are often not conclusive, so that a trial of dessicated thyroid, beginning with ½ gr. daily, should be tried. If hypothyroidism is present, the patient will feel much improved in 10 days. There is less tendency to toxemia of pregnancy while taking thyroid. — A. D. CAMPBELL, M.D. (Montreal, Canada) in *J. Omaha Mid-West Clin. Soc.* Jan. 1946.

NEW BOOKS

Any book reviewed in these columns will be procured for our readers if the order, addressed to CLINICAL MEDICINE, Waukegan, Ill., is accompanied by a check for the published price of the book.

Carbohydrate Metabolism (Correlation of Physiological, Biochemical and Clinical Aspects.)

By Samuel Soskin, M.D., Medical Director of Research, Michael Reese Hospital, Chicago, and R. Levine, M.D.—University of Chicago Press. 1946. $6.00.

A complete resume of the fundamentals of metabolism of foods, with special reference to carbohydrates, is presented by an experienced worker in the field. Knowledge of the vitamins and endocrines as they affect carbohydrate methabolism is also included. The book is ideal for the student or the clinician interested in diabetes, but is too involved for the average practitioner.

The Psychoanalytic Study of the Child (A Compilation)

An annual. Vol. I.—International Universities Press. 1945. $6.00.

It is difficult to make a fair estimate of any book which is a compilation because collections of papers are not unified by any central theme on which adequate criticism can be based.

This book consists of twenty-five articles: five on genetic problems, five on child analysis and child development, four on guidance work, six on problems of education and five reviews of other work. Some of the articles are extremely interesting and stimulating.

The article by Hartmann and Kris on "the genetic approach in psychoanalysis" is interesting because of their recommendation of systematic observation of life histories from birth to maturity. This emphasis on longitudinal research from the beginning of life onward is timely when it is recalled that much of the research has been in the opposite direction, estimating problems of childhood on a basis of analysis of adults.

The article by Spitz on "Hospitalism" is a fascinating study, in which the author compares the results of hospital routines in two different institutions on the development of the babies. It is emphasized that "the mother-child relationship during the first year is of overwhelming and unique importance, if we want to decrease the unavoidable and irreparable psychiatric consequences deriving from neglect during this period."

Sylvester includes an admirable chapter on "Psychogenic anorexia", which is well worth anybody's reading who is interested in this complicated problem.

The articles on childhood education and adolescent problems are full of meaning for the pediatrician who is concerned with more than just physical disturbances in children.

The physician who reads this book will be amply repaid in having delved into new lines of thought even though he may not agree with the conclusions. Many of the articles he can accept enthusiastically.—C.A.A.

The Treatment of Peritonitis and Its Aftermath

By Thomas B. Noble, Jr., M.D., F.I.C.S. Visiting Surgeon Methodist Hospital, St. Vincent Hospital, Hamilton Country Hospital, Consulting Staff, Indianapolis City Hospital. A Vernon Grindle, 1945. $6.50.

If the treatment advocated by the author can be carried out by the average surgeon, his work will be a landmark in surgery. The author boldly enters the obstructed or infected abdomen, frees all loops of bowel and removes all pus from abscesses, then sutures loops of bowel together (plicates) to prevent further adhesion formation and intestinal obstruction. This simple technic avoids intestinal resection and offers protection to raw peritoneal surfaces.

Principles of Dynamic Psychiatry (Including an Integrative Approach to Abnormal and Clinical Psychology.)

By Julius H. Masserman, M.D., Division of Psychiatry, University of Chicago.—W. B. Saunders Company. 1946. $5.00.

The author's purpose in adding this text to the psychiatric field is avowedly to ameliorate the too-prevalent concept "that psychiatry is a contentious cacophony of fantastic dogmas, contradictory nosologies and impractical theories somehow inserted into an otherwise 'scientific' university or medical school curriculum."

This biodynamic approach to psychiatric disorders and manifestations is interestingly illustrated by case reports and animal experiments. The author draws freely upon the school that best explains the dynamics whether it be the behaviorism of Watson, the psychoanalysis of Freud or the multiphasic psychobiology of Meyer.

The book contains a massive bibliography of 30 pages and a very usable glossary of the more frequent psychiatric terms.—E.J.D.

Synopsis of Physiology

By Rolland J. Main, Ph.D., Professor of Physiology, Medical College of Virginia, Richmond, Va.—C. V. Mosby. 1946. $3.50.

A brief summary of present day views on physiology, well classified so as to be readily available on any topic.

Human Embryology

By Bradley M. Patten, Professor of Anatomy, University of Michigan Medical School.— Blakiston Co. 1946. $7.00.

Embryology made easier, in text and over 1,000 illustrations. Embryology is correlated with anatomy and clinical appearances. The drawings are very clear and bring out details sharply, especially with the use of colors. Lucky will be the medical students who will use this guide to developmental anatomy. The studious surgeon and pediatrician will find much to interest them.

Modern Management in Clinical Medicine

By F. Kenneth Albrecht, M.D., Formerly Clinical Director, U.S. Marine Hospital, Baltimore.—Williams and Wilkins. 1946. $10.00.

The author has covered the recent literature in amazingly complete fashion so that one may find present day observations on almost every aspect of medicine and surgery, presented in summary form. The complete "instructions to patients" section should be of value to every physician who wishes his patients to follow his instructions *exactly*.

Hippocratic Wisdom (A Modern Appreciation of Ancient Medical Science)

By William F. Petersen, M.D., Chicago.— Charles C. Thomas. 1946. $5.00.

Quotations from the father of modern medicine, interspersed with interesting statements by the author, who furnishes much data and charts concerning the influence of weather on disease.

The Principles and Practice of Tropical Medicine

By L. Everard Napier, M.D., Visiting Lecturer on Tropical Medicine, Army Medical School.—The MacMillan Company. 1946. $11.00

A complete discussion of the various tropical diseases clarified by hundreds of illustrations and by a clear, definitive text.

Fractures, Dislocations and Sprains

By John Albert Key, M.D., Clinical Professor of Orthopedic Surgery, Washington University School of Medicine, St. Louis, and H. Earle Conwell, M.D., Orthopedic Surgeon to the Tennessee Coal, Iron and Railroad Company, Birmingham, Alabama. —C. V. Mosby Company. (4th Edition) 1946. $12.50.

All that you need to know concerning fractures, dislocations and sprains may be found in one book. It is practical. It is well illustrated with photographs and x-rays of cases, showing technic and results. As usual, the orthopedic surgeons do not mention procaine injections for ankle sprains.

Preoperative and Postoperative Treatment

Edited by Lt. Col. Robert L. Mason, M.C., A.U.S., and Harold A. Zintel, M.D., Department of Surgical Research, University of Pennsylvania.—W. B. Saunders Company. (Second Edition) 1946. $7.00.

A book for the surgeon at work, in which he will find answers to such questions as, "What causes fever following 'clean' surgical procedures?" "What is the best method of managing old surgical patients?" "Will oxygen relieve a dynamic ileus without use of gastrointestinal suction?" "Will heat or cold locally applied best relieve pain?" A number of authors have contributed sections dealing with various phases of preparing the patient for operation and caring for him afterward. This book is a rare combination of the immediately useful and the scientific aspects of such care.

The Mechanics of Obstetrics

By Norris W. Vaux, M.D. and Mario A. Castallo, M.D., Professor and Associate Professor of Obstetrics, Jefferson Medical College.—F. A. Davis Co. 1945. $4.00.

Obstetrics is a mechanical procedure which is ideally presented by illustrations, such as the 200 here published. The essentials of pelvimetry, determination of position and attitude, technics of normal and abnormal delivery in home and hospital are described in step by step sequence. A good "reminder" for the general practitioner and a useful synopsis for the student.

Diseases of the Skin

By George Clinton Andrews, M.D., Assoc. Clinical Professor Dermatology, Columbia University College of Physicians and Surgeons. New York, N.Y.—W. B. Saunders Company. (3rd Edition.) 1946. $10.00.

This volume contains many hundred clear photographs of various skin disorders. The text abounds with practical suggestions in therapy, such as the injection treatment of hemangiomas with quinine-urethane solution.

Cosmetics and Dermatitis

By Louis Schwartz, M.D. and Samuel Peck, M.D., U.S. Public Health Service. Paul Hoeber. 1946. $4.00.

The anatomy and physiology of the normal skin, allergic dermatoses, cosmetic dermatitis, the composition and action of creams, dentifrices, depilatories, perfumes and so on, and the treatment of cosmetic dermatitis are presented in a scientific manner.

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- ☐ Sulfaguen—Sulfa Cream, Impetigo
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